NOTICE OF ACTION - HOME AND COMMUNITY BASED SERVICES / SERIOUS EMOTIONAL DISTURBANCE WAIVER

State Form 51547 (3-04) / TS 0005

Name:	Medicaid number
Address (*number and street*)	
Address 2 (*number and street*)	County
City, state, ZIP code	Mailing date of notice

☐ **NEW APPLICATION** ☐ **ANNUAL REDETERMINATION** ☐ **CHANGE / UPDATE**

The Indiana Family and Social Services Administration has taken the action indicated below in regard to your application for, or changes of services under the Home and Community-Based Services (HCBS) Waiver Program.

FOR APPLICATION ONLY

Effective _____ your application for waiver services is ☐ Approved ☐ Denied ☐ Re-stated

Level of Care ☐ Hospital

Reason:

TO BE COMPLETED FOR ANNUAL REDETERMINATION, CHANGE / UPDATE, AND DISCONTINUANCE ONLY

Effective _____ your waiver services are ☐ Increased ☐ Decreased ☐ Discontinued ☐ Continued

Redetermination of Level of Care completed? ☐ Yes ☐ No

Reason:

Description of change:

SERVICES APPROVED

Provider	Service	Start Date	Stop Date	Total Units	Average Units / Month

Signature of CMHC / Wraparound Facilitator	Date (*month, day, year*)

IF YOU WISH TO APPEAL, PLEASE READ THE INFORMATION ON THE NEXT PAGE AND SIGN AND DATE BELOW.

☐ I WISH TO APPEAL THE ABOVE DECISION.

Reason:

Signature of applicant / recipient / guardian	Date (*month, day, year*)

See page 2 of this form for important information about your responsibilities and appeal rights.

YOUR APPEAL RIGHTS AS AN HCBS WAIVER SERVICES RECIPIENT

1. If you question the above action, you should discuss this matter with your waiver services Wraparound Facilitator (*Case Manager*).

2. **Your Right to Appeal and Have a Fair Hearing:**
If your application is denied, you may file an appeal within 30 days following the effective date of the action or 30 days following the date the notice was mailed (*whichever is later*).

As an HCBS Waiver recipient, if you disagree with any action taken on your HCBS Waiver case, you appeal within 30 days following the effective date of the action. However, your HCBS Waiver benefits will not continue unless you appeal prior to the effective date of the action. If you appeal and your waiver benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the hearing decision.

3. **How to Request an Appeal:**
If you wish to appeal this decision, you may request an appeal within 30 days of the date of receipt of this decision. Sign and return this form or send letter with your signature to: MS04, Indiana Family and Social Services Administration, hearings and Appeals, 402 W. Washington St., W392, Indianapolis, IN 46204.

If you send a letter rather than the Notice of Action, be sure that the letter contains your full name, address, and telephone number where you can be reached and state the name of the action you are appealing. A telephone request for an appeal cannot be accepted.

You will be notified in writing by the Family and Social Services Administration, Hearing and Appeals, of the date, time, and place for the hearing. Prior to or at the hearing, you have the right to examine the entire contents of your case record maintained by the Waiver Wraparound Facilitator.

You my represent yourself at the hearing or you authorized a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you have full opportunity to bring witnesses; establish all pertinent facts and circumstances, advance arguments without interference and question, or refute testimony or evidence presented.

Distribution of Notice of Action:

☐ Recipient / parent / guardian ☐ County OFC ☐ Assessment Agency (CMHC) ☐ Provider(s)

☐ DMHA Case File ☐ Other _____